

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2024 CERTIFICATE OF DEATH

Reg. Dist. No. 02003

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller		c. LENGTH OF STAY IN 1b 2 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thomas 85 X-3	
3. NAME OF DECEASED (Type or print) Mary		First Rose	Middle AVONA
4. DATE OF DEATH Feb. 9, 1960	Month Feb.	Day 9	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Guy Purrera		14. MOTHER'S MAIDEN NAME Rose Cordero	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Fred Pratt, Kitzmiller, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Causation of Liver with metastasis (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 7, 1960, to Feb. 8, 1960, that I last saw the deceased alive on Feb. 9, 1960, and that death occurred at 3:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Ralph Calandella M.D. Kitzmiller, Md. DATE SIGNED Feb. 9-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/60	22c. NAME OF CEMETERY OR CREMATORIAL Catholic Cem.
23. FUNERAL DIRECTOR'S SIGNATURE John Dease		ADDRESS Thomas, W. Va.	24a. REC'D BY REGISTRAR FEB 12 '60 DATE
24b. REGISTRAR'S SIGNATURE J. S. Tracy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAY 2018

2018

MAY 2018

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2023

CERTIFICATE OF DEATH

02004

Reg. Dist. No.

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death: Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		c. LENGTH OF STAY IN 1b 85 yrs.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print) Tryphena				First May	Middle Beckman	Last 2	4. DATE OF DEATH Month Day Year 8 19 60				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1874		9. AGE (In years lost birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John L. Fitzwater				14. MOTHER'S MAIDEN NAME Hephzibah George							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Edith O'Brien		Address Rural Swanton, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Urnitis DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 days 2 weeks Years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland	(County) Garrett	(State) Maryland				
21. I certify that I attended the deceased from 5-27, 1950, to 1-30, 1960, that I last saw the deceased alive on 1-30, 1960, and that death occurred at 10 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE: <i>James H. Fitzwater</i> M.D. ADDRESS (Street, city or town, state) <i>Oakland, Md.</i> DATE SIGNED <i>2-10-60</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/11/1960	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Garrett						
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home				ADDRESS Oakland, Maryland	24a. REC'D BY REGISTRAR DATE FEB 17 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					

CHAPTER NO. 33

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

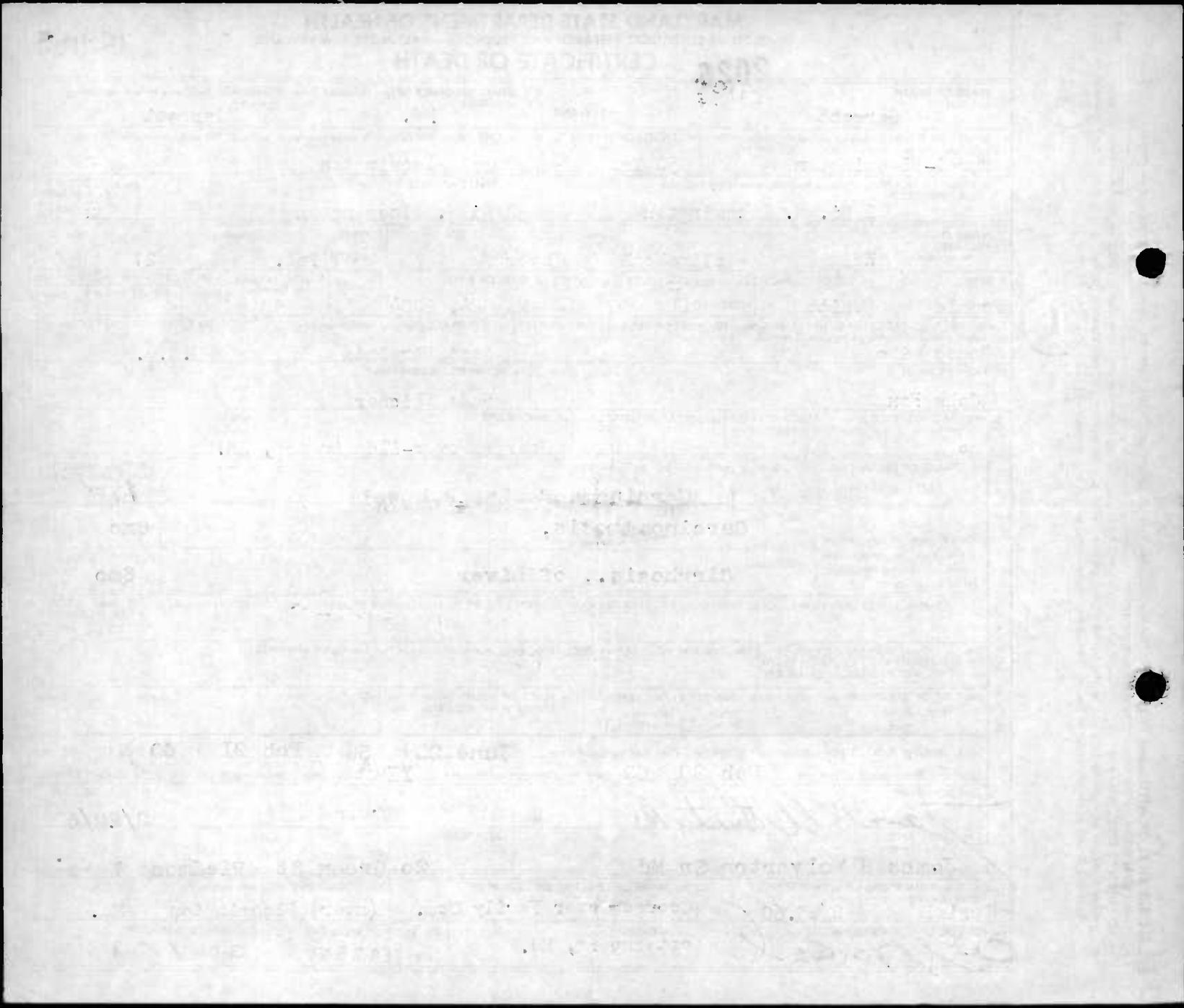
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2026

CERTIFICATE OF DEATH

02005

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bloomington			c. LENGTH OF STAY IN 1b 30 Yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Mi. W. Bloomington			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bloomington		
3. NAME OF DECEASED (Type or print) Edith			First Elizabeth	Middle Bever	Last
4. DATE OF DEATH Feb.			Month Feb.	Day 21	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1904	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Fox			14. MOTHER'S MAIDEN NAME Rada Whisner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.	17. INFORMANT George Peyer-Bloomington, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO Carcinoma of Large bowel			INTERVAL BETWEEN ONSET AND DEATH Years 8mo		
DUE TO Carcinomatosis, (c) DUE TO Cirrhosis., of Liver			6mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) George Peyer-Bloomington, Md.	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 20 1959</u> to <u>Feb 21, 1960</u> that (I) (we) last saw the deceased alive on <u>Feb 20 1960</u> , and that death occurred at <u>11M</u> , from the causes and on the date stated above.					
22a. SIGNATURE <i>James H. Wolverton Sr. Md.</i>			M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2/22/60</u>
22c. PHYSICIAN'S NAME (Type) James H. Wolverton Sr. Md.			22d. ADDRESS 20 Green St. Piedmont W. Va.		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 2/23.60	23c. NAME OF CEMETERY OR CREMATORIAL George Bever Family Cem.	23d. LOCATION (City, town, or county) (near) Bloomington Md.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ed. Boral</i>			ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE FEB 25 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2010 CERTIFICATE OF DEATH

02006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 2 1/2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GRANTSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JONAS	Middle EARL	Last BUTLER	4. DATE OF DEATH FEBRUARY 6TH 1960	Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1893	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MC CLELLAND GIDEON BUTLER		14. MOTHER'S MAIDEN NAME ELIZA ELLEN FULK					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 181-18-5591		17. INFORMANT GRAHAM WEEKS,		Address OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493 X <i>Pneumonia, Bilateral</i> INTERVAL BETWEEN ONSET AND DEATH 4 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Acute Congestive Heart Failure</i> 3 days							
DUE TO (c) <i>Uremia - Chronic Pyelonephritis</i> 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fracture of the Liver with Acute</i>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <i>Aug. 29, 1960</i> to <i>February 6, 1960</i> that I last saw the deceased alive on <i>February 6, 1960</i> , and that death occurred at <i>11:15 P.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. 21101 DATE SIGNED Feb 11 1960							
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>							
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D. OAKLAND, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/9/60	22c. NAME OF CEMETERY OR CREMATORIAL OAK GROVE	22d. LOCATION (City, town, or county) RURAL GRANTSVILLE GARRETT CO MD. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. Newman, Grantsville, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE FEB 11 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G257 2-29-60 et

2011

02007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND		c. LENGTH OF STAY IN 1b 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X HUTTON, MARYLAND		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First HARRISON	Middle William	Lost CASTEEL	4. DATE OF DEATH FEBRUARY	Month 16	Day 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH DECEMBER 31, 1879	9. AGE (In years last birthday) 80 <input checked="" type="checkbox"/>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Timber work in woods		11. BIRTHPLACE (State or foreign country) SANG RUN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN CASTEEL				14. MOTHER'S MAIDEN NAME LUCY DE WITT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no 220-10-2811		17. INFORMANT (SON) CLARENCE CASTEEL		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480 X DUE TO <i>Pneumonitis, bilateral</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Influenza</i> ONSET AND DEATH 3 weeks							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anemia - Chronic</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>February 1960</i> to <i>February 16, 1960</i> that I last saw the deceased alive on <i>February 16, 1960</i> , and that death occurred at 5:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>		ADDRESS (State, city or town, state) <i>77 Oak St. Oakland, Md. 17100</i> DATE SIGNED <i>17 Feb 60</i>					
PHYSICIAN'S NAME (Type) DR. HERBERT H. LEIGHTON		OAKLAND, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/1960		22c. NAME OF CEMETERY OR CREMATORIUM Sang Run Cemetery		22d. LOCATION (City, town, or county) Garrett County, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

61-200128-11240 STATE OF ILLINOIS

CERTIFICATE OF DEATH

DEATH CERTIFICATE

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02008

2012 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 16 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK	
3. NAME OF DECEASED (Type or print) GEORGE		4. DATE OF DEATH Month FEB. Day 28 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 1, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Work	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac		14. MOTHER'S MAIDEN NAME Mariah Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. W.W. #1 214-20-4363	
17. INFORMANT (SELF) GEORGE CHANEY		Address MT. LAKE PARK, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Uremia INTERVAL BETWEEN ONSET AND DEATH 3 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anasarca - Pleural, Peritoneal, Pneumothorax 15 days (c) Cardio - Renal Insufficiency - Chronic 5 years or more			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 1960, to Feb 28, 1960 , that I last saw the deceased alive on Feb 27, 1960 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. 21206	
DATE SIGNED 27 Feb 60			
PHYSICIAN'S NAME (Type) DR. HERBERT H. LEIGHTON		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/1960	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		22d. LOCATION Baltimore, Md. (State) 5501 Frederick Ave.	
23. FUNERAL DIRECTOR'S SIGNATURE He. Leighton		ADDRESS Oakland, Md.	
		24a. REC'D BY REGISTRAR DATE MAR 2 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Russ	

BY PHONETICS—HANDBOOK PREPARED BY STATE BOARD OF

EDUCATION FOR STANDARDS

1933

2011 RELEASE UNDER THE FOIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02009

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the date "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2013		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Garrett		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Garrett	
Oakland		6 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Garrett County Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First James	Middle O.	Last Cheratti	4. DATE OF DEATH February 1 19 60
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/24/1884	9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Lithuania	
Miner				12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 167-07-8868		17. INFORMANT Mrs. Bess Cuppett, Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2044 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Pneumonia, terminal			
{ (b) DUE TO Leukemia				6 mos.	
{ (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. J. H. Feaster, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-1-60	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-60	22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery	22d. LOCATION (City, town, or county) Oakland Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR FEB 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause
VS. A15ME(5) SM 9/55					

STATE OF ALABAMA
DEPARTMENT OF HEALTH-HEALTH PROMOTION &
WELLNESS DIVISION
ANIMALS CERTIFICATE OF DEATH

NAME OF ANIMAL	SEX	AGE	WEIGHT	DATE OF DEATH	CAUSE OF DEATH
BREED					
SPECIES					
OWNER'S NAME					
OWNER'S ADDRESS					
OWNER'S CITY, STATE, ZIP					
OWNER'S PHONE NUMBER					
NAME OF VETERINARIAN					
VETERINARIAN'S ADDRESS					
VETERINARIAN'S CITY, STATE, ZIP					
VETERINARIAN'S PHONE NUMBER					
NAME OF PERSON FILING CERTIFICATE					
PERSON FILING CERTIFICATE'S ADDRESS					
PERSON FILING CERTIFICATE'S CITY, STATE, ZIP					
PERSON FILING CERTIFICATE'S PHONE NUMBER					
NAME OF PERSON SIGNING CERTIFICATE					
SIGNATURE					
DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2014 CERTIFICATE OF DEATH

Reg. Dist. No.

02010

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		0102.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Janet	Middle Coyle	Lost	4. DATE OF DEATH	Month Feb.	Day 18	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1875	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mesiah Preston				14. MOTHER'S MAIDEN NAME Anna Greenhorn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. William Varner—Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO				Pneumonitis, terminal INTERVAL BETWEEN ONSET AND DEATH 3 days			
DUE TO Arteriosclerosis, generalized, (c)				Auricular fibrillation, 2 months 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral vascular accident, right, years ago				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-60, 1960, to 2-18-60, 1960, that I last saw the deceased alive on 2-17-60, 1960, and that death occurred at 3 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE James H. Feaster, Jr., M.D.		ADDRESS (Street, city or town, state) 58 2nd. St., Oakland, Md. DATE SIGNED 2-19-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/60		22c. NAME OF CEMETERY OR CREMATORIAL Philos		22d. LOCATION (City, town, or county) Westernport (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Boal		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE Cathleen S. Turner	

MANAUS STATE GOVERNMENT OF RIO GRANDE DO SUL

STATE CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2015 CERTIFICATE OF DEATH

Reg. Dist. No. 02011

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland.		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 72 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oakland,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 63 Wilson St.				d. STREET ADDRESS 63 Wilson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilbur		Middle Lawton		Last Davis		4. DATE OF DEATH Month February	Day 29, 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1887		9. AGE (In years 17 yrs. 1st birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance work for Gas Co.		10b. KIND OF BUSINESS OR INDUSTRY Gas Co.		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles S. Davis		14. MOTHER'S MAIDEN NAME Sarah Lawton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Richard Davis		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 38 21st		20f. (City or town) Oakland, Md.	(County) (State)
21. I certify that I attended the deceased from _____ 1953, 19 _____ to _____ 1960, 1960, that I last saw the deceased alive on _____ 20, 1960, and that death occurred at 4:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE James H. Feaster Jr., M. D.						ADDRESS (Street, city or town, state) 38 21st	
22a. BURIAL, CREMATION, OR OTHER (Specify) Burial		22b. DATE THEREOF 3/3/1960		22c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE MAR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

STATE OF SOUTH DAKOTA
CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - DIVISION OF PUBLIC HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2027

CERTIFICATE OF DEATH

Reg. Dist. No.

02012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park lot #2		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park		b. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ida	Middle Ellen	Lost Fike	4. DATE OF DEATH	Month 2	Day 25	Year 1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White			Sept. 3, 1875	84 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Hoyes, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Conway		14. MOTHER'S MAIDEN NAME Margaret Lininger		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mildred Hoye		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Hemorrhage Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause lost. (b) DUE TO Coronary Heart Disease (c) DUE TO Hypertension		
						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 10 yrs.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE Ralph C. Landell M.D.		ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state) Ralph C. Landell M.D. Kitzmiller MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/26/1960		22c. NAME OF CEMETERY OR CREMATORIAL Steele Cemetery		22d. LOCATION (City, town, or county) (State) Friendsville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR DATE MAR 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

200

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2016 CERTIFICATE OF DEATH

02013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,			c. LENGTH OF STAY IN 1b 18 Mo.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Friendsville,		
3. NAME OF DECEASED (Type or print) First Rachel Middle Hoff Last Frantz			4. DATE OF DEATH February 6, Month Year 1960		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 1, 1873		9. AGE (In years at birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY Own Home		
11. BIRTHPLACE (State or foreign country) Maryland.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamine Hoff			14. MOTHER'S MAIDEN NAME Rebecca Ringer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. --- 17. INFORMANT Merle D. Frantz Address Friendsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 days Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 50 21st Oakland, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1959</u> to <u>Jan 4, 1960</u> , that I last saw the deceased alive on <u>Feb 3, 1960</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE James H. Feaster Jr., M. D.			ADDRESS (Street, city or town, state) 50 21st Oakland, Md. DATE SIGNED 2-7-60		
22a. BURIAL, CREMATION BUTIAL			22b. DATE THEREOF 2/9/1960		
22c. NAME OF CEMETERY OR CREMATORIAL Blooming Rose Cemetery			22d. LOCATION (City, town, or county) (State) Garrett County, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton			24a. REC'D BY REGISTRAR FEB 10 '60		
ADDRESS Oakland, Md.			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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THE STATE OF NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2017 CERTIFICATE OF DEATH

Reg. Dist. No.

02014

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Truman	Middle Friend	4. DATE OF DEATH 2 10 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk.	10b. KIND OF BUSINESS OR INDUSTRY unk.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Edward Friend	14. MOTHER'S MAIDEN NAME Rachael Jenkins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk.	16. SOCIAL SECURITY NO. -----	17. INFORMANT Mrs. M. Jones Friendsville, Md.	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis (c)		Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sequelae		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sequelae	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 17, 1960, to 2-8, 1960, that I last saw the deceased alive on 2-8, 1960, and that death occurred at 8:10 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED 2-10-60
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ACTUAL SIGNATURE James H. Foster, M.D.	PHYSICIAN'S NAME (Type) James H. Foster, M.D.
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22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2/12/60	22c. NAME OF CEMETERY OR CREMATORIAL Steele Cemetery	22d. LOCATION (City, town, or county) Friendsville, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home	ADDRESS Oakland, Maryland	24a. REC'D BY REGISTRAR DATE FEB 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.VS A15 (4)
15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02015

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Garrett		b. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b mins.	
Oakland		X t. Lake Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First James	Middle E. Hubbard
4. DATE OF DEATH		Month 2	Day 21
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 1, 1891
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY
68 yrs.		Brick Layer	12. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN HUBBARD		CATHERINE DOWNS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
NO		LILLIAN I. MASON 7407 SCHOOL AVE #22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation, Pulmonary Edema			
526X DUE TO Cor Pulmonale			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) -----			
DUE TO (c) Bronchiectasis, bilateral; marked years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
Hour o. m. p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr.			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 2-21-60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		2-24-60	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
OAK LAWN CEM.		7225 EASTERN BLVD., BALTO. CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Charles S. Zeiler		901 S. CONKLING ST. BALTO., MD.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
FEB 25 1960		John S. Feaster	
DATE			

MANHATTAN-SUBDIVISION OF HANNAH-GATES
SOLICITOR GENERAL'S EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02016

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		d. STREET ADDRESS 323 Baltimore Ave.											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				d. STREET ADDRESS 323 Baltimore Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Blanche		First	Middle	Lost	Hughes	Month	Day	Year									
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1905		9. AGE (In years from birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John Hughes		14. MOTHER'S MAIDEN NAME Mae Hitchins															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Harry Hughes Cash Valley Rd.		Cumberland, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Auricular fibrillation</u> DUE TO (c) <u>Arteriosclerotic, cardio-renal disease.</u>						INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>10-19-59</u> , 19, to <u>2-18-60</u> , 19, that I last saw the deceased alive on <u>2-18-60</u> , 19, and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>James H. Feaster Jr.</u> M.D.														ADDRESS (Street, city or town, state)		DATE SIGNED <u>2-22-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/1960		22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Mem. Park		22d. LOCATION (City, town, or county) Frostburg, Md.								(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Duest Jr. Frostburg, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR FEB 25 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

REG. NO. 1000

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REG. NO. 1000

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REG. NO. 1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02017

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 2 hrs.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,				
3. NAME OF DECEASED (Type or print) First Abraham Ketterman Middle King		4. DATE OF DEATH Month February Day 15, Year 19 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 9, 1880	9. AGE (In years from birthday) 79 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer on Farms, Coal mines, etc.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland.				
13. FATHER'S NAME John King		14. MOTHER'S MAIDEN NAME Sarah Ayers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-2996 17. INFORMANT Mrs. Myrtle Hinebaugh Deer Park, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with extensive hemorrhage secondary to DUE TO trauma						
INTERVAL BETWEEN ONSET AND DEATH 6 hrs.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fell while fixing a fire, striking head on floor.				
20c. TIME OF INJURY Hour 5		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) Rural Deer Park	(County) Garr. Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-15-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/1960	22c. NAME OF CEMETERY OR CREMATORIUM King Cemetery, near	22d. LOCATION (City, town, or county) Mt. Lake Park, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE H. G. Leighton	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE FEB 24 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS Box 73		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Margaret		First Margaret	Middle Daisy	Last Knotts	4. DATE OF DEATH February 10 1960	Month February	Day 10	Year 1960
5. SEX Females	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5-23-83	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME William Shaffer				14. MOTHER'S MAIDEN NAME Julia Nordeck				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Floyd Carskadon (Son-in-law)		Address Box 73, Crellin, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Hyper tension								
INTERVAL BETWEEN ONSET AND DEATH 4 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Hyper tension		DUE TO Hyper tension						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1-25, 1955 to 2-10, 1960 , that I last saw the deceased alive on 2-10, 1960 , and that death occurred at 11:05 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Andrew E. Mance</i>		ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 1960						
PHYSICIAN'S NAME (Type) Dr. Andrew E. Mance,		Oakland, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/1960		22c. NAME OF CEMETERY OR CREMATORIUM Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>He Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02019

2028

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Penns.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
Grantsville, Md.		2 months		Springs, Penns.		75 x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Goodwill Mennonite Home, Grantsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
MARY		ETTA	LOHR		Feb.	1	1960		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
Female	White			Jan. 19, 1885	75				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
House work		Own home		Bittinger, Md.		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Eli Lohr				Barbara Bender					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
				none		Mrs. Emma Miller, Springs, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH									
332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Generalized arteriosclerosis</u>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I attended the deceased from 3-30, 1955, to 2-1, 1960, that I last saw the deceased alive on 1-28, 1960, and that death occurred at 10:15 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE LEONARD L Rock MD		ADDRESS (Street, city or town, state) 209 NORTH ST Meyersdale Pa							
PHYSICIAN'S NAME (Type) LEONARD L Rock MD		DATE SIGNED 2/2/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/60		22c. NAME OF CEMETERY OR CREMATORIAL Springs Mennonite		22d. LOCATION (City, town, or county) Springs, Somerset Co., Pa.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Nora J Newman		ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR FEB 5 '60		24b. REGISTRAR'S SIGNATURE Carrie S. Krause			

TEXAS STATE DEPARTMENT OF
CERIFICATE OF

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2029 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R D #2 Swanton			c. LENGTH OF STAY IN lb 50 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Glade Community			d. STREET ADDRESS R D #2			
3. NAME OF -DECEASED (Type or print) First Morris			4. DATE OF DEATH February 20, 1960			
Middle Newton			Month Day			
Last Merrill			Year Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1876	9. AGE (in years last birthday) 83 yrs.	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			IF UNDER 1YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Woods worker			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland.
						12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Isaac Merrill			14. MOTHER'S MAIDEN NAME Mary Savage			
						Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. ---			17. INFORMANT (Daughter) Mrs. Betty Lazelle
						Morgantown, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute						Minutes
DUE TO 420.0						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease.						Years
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.			Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Nutrol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>						DATE SIGNED 2-22-60
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/1960		22c. NAME OF CEMETERY OR CREMATORIUM McRobie Cemetery		22d. LOCATION (City, town, or county) near Swanton, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Powell</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

ST. BARTHOLOMAEUS-EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	TIME OF DEATH	PLACE OF DEATH
John Smith	50	Male	Heart Disease	10:00 AM	At Home
ADDRESS					
123 Main Street, Anytown, USA					
NAME OF DOCTOR					
Dr. John Doe, M.D.					
NAME OF HOSPITAL					
Anytown Hospital					
NAME OF FUNERAL DIRECTOR					
Anytown Funeral Home					
NAME OF CEMETERY					
Anytown Cemetery					
NAME OF ATTORNEY					
None					
NAME OF NOTARY PUBLIC					
John Smith, Notary Public					
NAME OF SIGNER					
John Smith					
DATE					
10/10/2023					

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the register within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M
B P

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2022 CERTIFICATE OF DEATH

Reg. Dist. No.

02021

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place) 8 DAYS		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		COUNTY GARRETT STREET ADDRESS (If rural give location) ROUTE #1, POX #17	
GARRETT OAKLAND HOSPITAL OR INSTITUTION OR STREET ADDRESS GARRETT COUNTY MEMORIAL HOSPITAL				FRIENDSVILLE			
3. NAME OF DECEASED (Type or Print) BENJAMIN WALTER MEYERS				4. DATE (Month) (Day) (Year) OF DEATH FEB. 10 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH OCTOBER 16, 1889	9. AGE last birthday 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hrs. Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				11. BIRTHPLACE (State or foreign country) W. Va			
13. FATHER'S NAME ISAAC MEYERS				14. MOTHER'S MAIDEN NAME ANNABELLE TEETS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 220-05-2294			
17. INFORMANT & ADDRESS MRS. BENJAMIN MEYERS, FRIENDSVILLE, MD.				ROUTE #1, BOX #17			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <i>Cereumia</i> ANTECEDENT CAUSE(S) DUE TO <i>Pneumonia</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Arterio sclerosis</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Arterio sclerosis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION None				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None				21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 11, 1956, to Feb. 10, 1960, that I last saw the deceased alive on Feb. 10, 1960, and that death occurred at 3:30 AM, from the causes and on the date stated above. SIGNATURE <i>A. E. Hance</i> ADDRESS (Street, city, town, state) <i>Oakland Rd</i> DATE SIGNED <i>10 Feb 60</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2-13-1960		NAME OF CEMETERY OR CEMETORY Webbs Chapel Cem. Hazelton Ave		LOCATION (City, town, or county) Hazelton Ave (State)	
24. REC'D BY REGISTRAR DATE FEB 15 '60		REGISTRAR'S SIGNATURE Arthur S. Hance		25. FUNERAL DIRECTOR'S SIGNATURE W. A. Rodakowski - Markleyburg Pa		ADDRESS	

BY AIR MAIL - STAMPED TO THE TRADED STATE OF AYUTTHAYA

STAMP TO BE ADDED

STAMP TO BE ADDED

2805

EN. N. [REDACTED] INT. NAMELESS PERIOD

+PS5-20-025

OR

OR

NAME

NAME

-Kuttiyot and Ko. Ltd. 201-81-3 11/19/83
Kuttiyot and Ko. Ltd. 201-81-3 11/19/83

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2030

CERTIFICATE OF DEATH

Reg. Dist. No.

02022

1. PLACE OF DEATH o. COUNTY		GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		MARYLAND MONTGOMERY b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		c. LENGTH OF STAY IN lb 18MO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		1526-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DUPPETT REST Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle DAVID	Last MILLER	4. DATE OF DEATH	Month 2	Day 12	Year 1960
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 22, 1899	9. AGE (In years lost/birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SANDER		10b. KIND OF BUSINESS OR INDUSTRY Electronics		11. BIRTHPLACE (State or foreign country) Moore, W.Va.		12. CITIZEN OF WHAT COUNTRY? West		
13. FATHER'S NAME FRANKLIN MILLER		14. MOTHER'S MAIDEN NAME Minnie CRAWFORD						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-03-062		17. INFORMANT Mrs. G. J. MILLER, Rockville		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0		DUE TO Pyonephritis				INTERVAL BETWEEN ONSET AND DEATH 4 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b)				1 yr		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from <u>Apr. 31</u> , 1958, to <u>Feb. 12</u> , 1960, that I last saw the deceased alive on <u>Feb. 12</u> , 1960, and that death occurred at <u>1149A M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>E.J. Baumgartner</u> M.D. <u>25 Alder St</u> PHYSICIAN'S NAME (Type) <u>E.J. BAUMGARTNER</u> ADDRESS <u>OAKLAND MD.</u>								ADDRESS (Street, city or town, state) DATE SIGNED <u>1149A M</u> <u>2/12/60</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) 150310		22b. DATE THEREOF 2/15/60		22c. NAME OF CEMETERY OR CREMATORIAL MENNEAR CEM.		22d. LOCATION (City, town, or county) HENDERSON (State) <u>W.Va.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. A. Deane, Thomas, M.D.</u>		ADDRESS		24a. REC'D BY REGISTRAR FEB 15 60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

81.37001148-172.838770 TSIEM TIA WO SIAZ QIGA 77.10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2031

CERTIFICATE OF DEATH

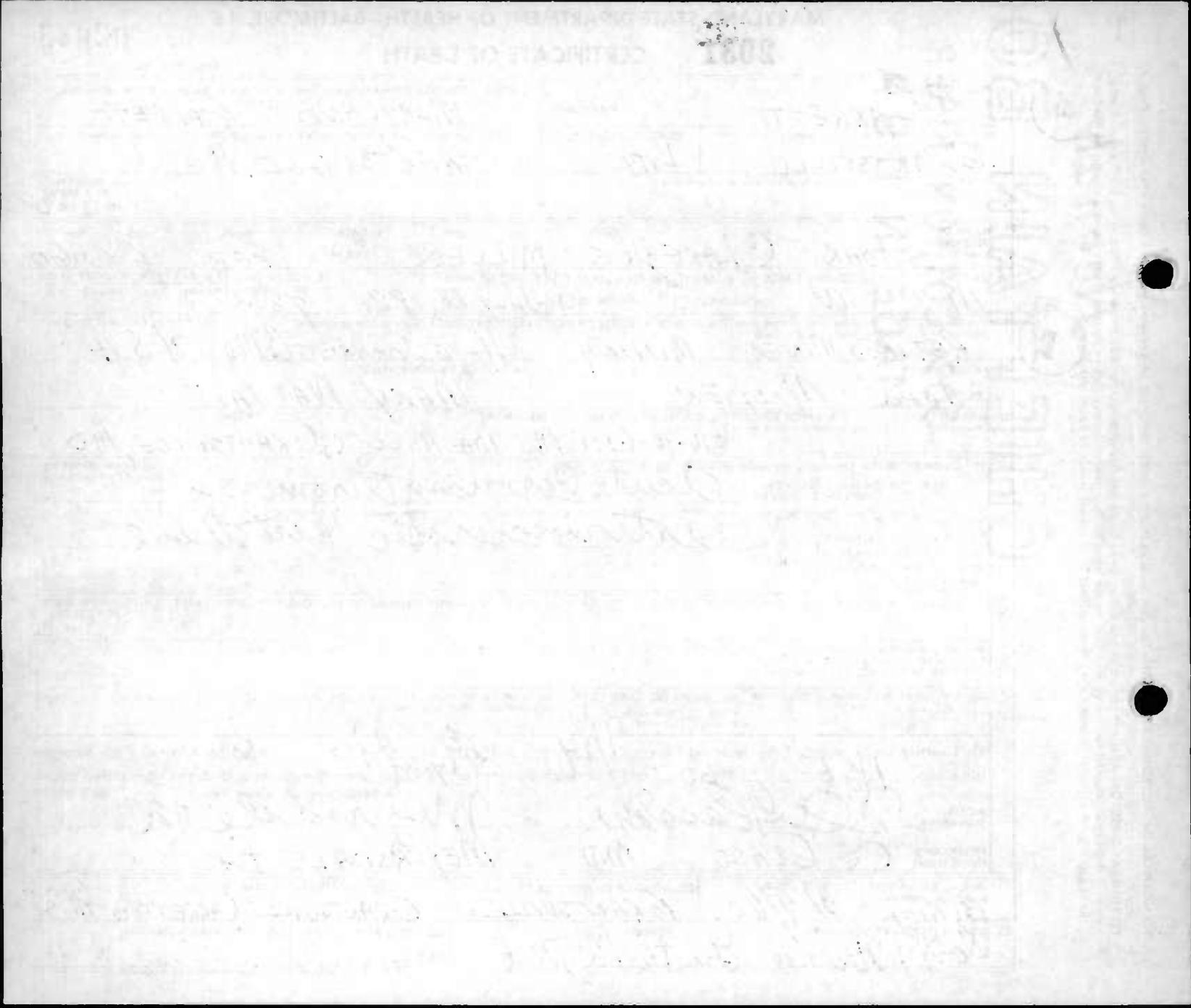
Reg. Dist. No.

112023

1. PLACE OF DEATH a. COUNTY <i>GARRETT</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>GARRETT</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GRANTSVILLE</i>		c. LENGTH OF STAY IN 1b <i>LIFE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GRANTSVILLE, MD</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>JOHN</i>	Middle <i>CLARENCE</i>	Last <i>MILLER</i>	4. DATE OF DEATH <i>FEB. 6 1960</i>	Month <i>FEB.</i>	Day <i>6</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 18, 1881</i>	9. AGE (In years lost birthday) yrs. <i>78</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED MINER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MINING</i>		11. BIRTHPLACE (State or foreign country) <i>HOPES, GARRETT CO MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>21.5.4.</i>	
13. FATHER'S NAME <i>JOHN MILLER</i>		14. MOTHER'S MAIDEN NAME <i>MARY NATHAN</i>		INFORMANT <i>MRS. JOA MILLER, GRANTSVILLE MD</i>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>216-10-6221</i>		17. CAUSE OF DEATH [Enter only one cause per line. (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		18. INTERVAL BETWEEN ONSET AND DEATH	
				DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)			
				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>7/14</i> , 19 <i>59</i> , to <i>2/6</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/25</i> , 19 <i>60</i> , and that death occurred at <i>7:00 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>MEYERSDALE PA</i>		DATE SIGNED			
ACTUAL SIGNATURE <i>CC GLASS M.D.</i>		PHYSICIAN'S NAME (Type) <i>CC GLASS M.D.</i>		22d. LOCATION (City, town, or county) (State) <i>GRANTSVILLE, GARRETT CO MD</i>			
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22f. DATE THEREOF <i>4/9/60</i>		22g. NAME OF CEMETERY OR CREMATORIAL <i>GRANTSVILLE</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J Newman, Grantsville, Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>FEB 11 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2032

CERTIFICATE OF DEATH

Reg. Dist. No.

02024

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLOOMINGTON		c. LENGTH OF STAY IN 1b RURAL and give nearest town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLOOMINGTON	
3. NAME OF DECEASED (Type or print) ROBERT		First ROBERT	Middle CECIL
4. DATE OF DEATH FEB. 14 1960		Lost MOOREHEAD	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 17, 1883
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer		10b. KIND OF BUSINESS OR INDUSTRY W.Va. P. & P. Co.	11. BIRTHPLACE (State or foreign country) BLOOMINGTON, MD.
13. FATHER'S NAME ROBERT W. MOOREHEAD		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 217-05-0263	17. INFORMANT CARROLL MOOREHEAD, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal Dis		INTERVAL BETWEEN ONSET AND DEATH 3mo	
442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterio sclerosis., DUE TO DUE TO (c)		8yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 2nd, 1960 to Feb 14, 1960 that I last saw the deceased alive on Feb 14, 1960 , and that death occurred at 10.30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James H. Wolverton, Sr.</i>		ADDRESS (Street, city or town, state) Piedmont, W. Va.	
PHYSICIAN'S NAME (Type) JAS. H. WOLVERTON, SR.		DATE SIGNED 2/15/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 17/60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS PHILOS CEMETERY PIEDMONT, W. VA.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. F. Fredrick Jr.</i>		22d. LOCATION (City, town, or county) WESTERNPORT, MD.	24a. REC'D BY REGISTRAR DATE FEB 16 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
X
M
X
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✓
2
2
11
2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, interment, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02025

1. PLACE OF DEATH a. COUNTY GARRETT			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE MD			c. LENGTH OF STAY IN lb LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD			
d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sonya Clair Patton			4. DATE OF DEATH	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JAN. 24 1936 24 yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY WORKER			10b. KIND OF BUSINESS OR INDUSTRY UNDER CLOTHING	11. BIRTHPLACE (State or foreign country) GRANTSVILLE, MD		
13. FATHER'S NAME DAVID PAUL			14. MOTHER'S MAIDEN NAME BETTY PATTON			12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 220-34-1372	17. INFORMANT	Address Mrs. Ophelia Patton, Grantsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning						Hours
891.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went to sleep in auto with motor running.			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage	20f. (City or town) Grantsville	(County) Garr.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>			DATE SIGNED 2-15-60			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/16/60	22c. NAME OF CEMETERY OR CREMATORIAL GRANTSVILLE		22d. LOCATION (City, town, or county) GRANTSVILLE GARRETT Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. Newman, Grantsville MD</i>			ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
					DATE FEB 18 '60	<i>On file 9 A.M.</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2034

CERTIFICATE OF DEATH

Reg. Dist. No.

02026

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weber Nursing Home		d. STREET ADDRESS 1 Mi. East Deer Park		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora		First Susan	Middle Reis	Last February	4. DATE OF DEATH 9, 1960
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 22, 1876	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.	
13. FATHER'S NAME William H. Wright		14. MOTHER'S MAIDEN NAME Harriett Harvey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Pleasant Thrasher Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-7 , 19 55 to 2-9 , 19 60 , that I last saw the deceased alive on 2-9 , 19 60 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Andrew E. Mance</i>	M.D.		ADDRESS (Street, city or town, state) Oakland		DATE SIGNED 107-660
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.	Oakland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/1960	22c. NAME OF CEMETERY OR CREMATORIUM Deer Park Cemetery		22d. LOCATION (City, town, or county) Deer Park, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HC Reighton</i>	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR FEB 15 '60		24b. REGISTRAR'S SIGNATURE <i>John E. Tamm</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wever Nursing Home			d. STREET ADDRESS R. D. #2		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Cora	Middle Blanche	Last Shaffer	4. DATE OF DEATH	Month February Day 8, Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec. 3, 1888	9. AGE (In years 71 birthday) yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		
11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel W. Dodge			14. MOTHER'S MAIDEN NAME Hulda Harned		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Elmer Shaffer R. D. 2 Oakland, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0			INTERVAL BETWEEN ONSET AND DEATH 5 min.		
DUE TO Cardiac Arrest					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Pyleitic			3 mos.		
(c) Brain Tumor			Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October , 19 59 , to Febr 8, 1960 , that I last saw the deceased alive on February 5, 1960 , and that death occurred at 10:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aurora, Md. DATE SIGNED 2-10-60					
ACTUAL SIGNATURE Alfred Owre, Jr. M.D. PHYSICIAN'S NAME (Type) ALFRED OWRE, JR. M.D.					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/1960	22c. NAME OF CEMETERY OR CREMATORIAL Red House Cemetery	22d. LOCATION (City, town, or county) Garrett County, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HC Keeglyton			ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE FEB 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Keeglyton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02028

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MARYLAND b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman			c. LENGTH OF STAY IN 1b 40 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Mi. North Gorman			d. STREET ADDRESS 2 Mi. North Gorman		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Zella King		First Zella	Middle King	Last Shreve	4. DATE OF DEATH Month February Day 10, Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 13, 1892	9. AGE (In years and birthday) 67 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William E. King			14. MOTHER'S MAIDEN NAME Ida Everett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Edna Clark Bayard, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Acute Dehydration - Vomiting DUE TO (c) Influenza + Diarrhea INTERVAL BETWEEN ONSET AND DEATH 5 day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 012.1 Tuberculosis of left hip					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2:30P			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County) (State)
21. I certify that I attended the deceased from June , 19 57 , to Feb. 10 , 19 60 , that I last saw the deceased alive on Feb. 9 , 19 60 , and that death occurred at M.D. from the causes and on the date stated above. ACTUAL SIGNATURE Herbert H. Leighton ADDRESS (Street, city or town, state) 77 Oak St, Oakland, Md. DATE SIGNED 12 Feb 60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/1960	22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove Cemetery	22d. LOCATION (City, town, or county) near Gorman, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Her. Leighton			ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE FEB 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2023

CERTIFICATE OF DEATH

Reg. Dist. No.

02029

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland.		b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Deer Park,					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				d. STREET ADDRESS 5 Mi. S. Deer Park		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George		First W.	Middle .	Last Walter	4. DATE OF DEATH February 16, 1960	Month February	Day 16	Year 1960	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb. 11, 1865	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Walter				14. MOTHER'S MAIDEN NAME Margaret White					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Lester White		Address Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Conjunctive Deer faller Anemia, chronic C-V Disease				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland		(County) Garrett County	(State) Md.
21. I certify that I attended the deceased from <u>now</u> , 19 <u>59</u> , to <u>Feb 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>60</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state) M.D. <u>Deer Park St</u>			
ACTUAL SIGNATURE <u>E. I. Baumgartner</u>						DATE SIGNED <u>2/18/60</u>			
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D.				20. PLACE OF BURIAL, Cremation, or Removal (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORIUM White Church Cemetery		22d. LOCATION (City, town, or county) Garrett County, Md.	
22b. DATE THEREOF 2/20/1960		22c. NAME OF CEMETERY OR CREMATORIUM White Church Cemetery		22d. LOCATION (City, town, or county) Garrett County, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Legg</u>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Mann</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2037

CERTIFICATE OF DEATH

02050

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park			c. LENGTH OF STAY IN 1b 2 Weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weber Nursing Home			Mt. Storm		
3. NAME OF DECEASED (Type or print) Henry Thomas Warnick			4. DATE OF DEATH February 25, 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 5, 1875	9. AGE (In years lost, birthday) 84 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal Industry	11. BIRTHPLACE (State or foreign country) Bloomington, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Vincent Warnick			14. MOTHER'S MAIDEN NAME unk.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None	17. INFORMANT Harry J. Warnick	Address Mt. Storm, Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebral Vascular Accident</i> DUE TO (c) <i>Anteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Previous Cerebral Thrombosis Dec-64</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-22</u> , 19 <u>60</u> , to <u>2-22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-24-60</u> , 19 <u>60</u> , and that death occurred at <u>130 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Joe H. Feaster, Jr.</i>			ADDRESS (Street, city or town, state) <u>58 2d st Oakland, Ca 94160</u> DATE SIGNED <u>3-21-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/28/60	22c. NAME OF CEMETERY OR CREMATORIAL Shaffer Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Storm, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Mimich Funeral Home			ADDRESS Oakland, Maryland	24a. REC'D BY REGISTRAR Date 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02031

1. PLACE OF DEATH a. COUNTY		2039 Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		c. LENGTH OF STAY IN 1b mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rt # 1. Oakland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Robert	Middle Carl	Last Winters	4. DATE OF DEATH 2 19 1960		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 21, 1906	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Winters		14. MOTHER'S MAIDEN NAME Ellazar Houser					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-12-2070		17. INFORMANT Mary Winters		Address Swallow Falls, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 420.1 PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial infarction, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland	(County) Maryland	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-20-60			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/22/60	22c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery	22d. LOCATION (City, town, or county) Oakland		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR FEB 24 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Traut		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH CERTIFICATE

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